

680

## CERTIFICATE OF DEATH

Reg. Dist. No.

00675

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural STREET</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural STREET X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SCARBORO ROAD</u>				d. STREET ADDRESS <u>SCARBORO ROAD 1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE BELLE BUSH</u>				4. DATE OF DEATH Month Day Year <u>JAN 24 1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 16 1887</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>JARRETTVILLE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN GROSS</u>				14. MOTHER'S MAIDEN NAME <u>BESSIE BURKINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		INFORMANT Address <u>J. KENNETH BUSH STREET. MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Generalized Atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 MINUTED</u> <u>8 hr</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 1959</u> , 19 <u>59</u> , to <u>Jan 24</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>December 12</u> , 19 <u>60</u> , and that death occurred at <u>330 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dudley Phillips MD</u>		ADDRESS (Street, city or town, state) <u>DARLINGTON, Maryland</u> DATE SIGNED <u>1/24/61</u>					
PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/27/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>William Matters</u>		22d. LOCATION (City, town, or county) (State) <u>Coopertown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Charles E. Kurtz Jarrettsville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 26 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

CENTRIFUGAL OF DEATH

020

SECTION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
1SM 9/59

1

681

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00676

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVER de GRACE</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>1 STREET</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>PURLEE WILSON CARR</b>				4. DATE OF DEATH Month Day Year <b>JAN 9 1961</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 6, 1887</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BOILER FIREMAN</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>JESSE CARR</b>				14. MOTHER'S MAIDEN NAME <b>SARAH WARNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-10-8326</b>			
17. INFORMANT Address <b>MRS. SADIE E. CARR, STREET, MD.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Infarction</b> 464X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Thrombophlebitis</b> (c) <b>Carcinoma of Stomach and Esophagus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 day</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 day</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>March 12 1960</b> to <b>1/9/61</b> , 19____, that (I) (we) last saw the deceased alive on <b>1/9/61</b> , 19____, and that death occurred at <b>12:45</b> AM, from the causes and on the date stated above.							
22a. SIGNATURE <b>Dudley Phillips MD</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/9/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dudley Phillips MD</b>				22d. ADDRESS <b>DARLINGTON, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>1-11-1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EMORY</b>	
23d. LOCATION (City, town, or county) (State) <b>STREET, MD.</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>John H. Harkins</b>				ADDRESS <b>DELTA, PA.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 11 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraw</b>							

CERTIFICATE OF DEATH

13

NAME OF DECEASED: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BIRTH: [illegible]

SEX: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

MARRIAGE: [illegible]

PREVIOUS MARRIAGES: [illegible]

DATE OF MARRIAGE: [illegible]

NAME OF WIFE: [illegible]

NAME OF HUSBAND: [illegible]

DATE OF DEATH: [illegible]

1  
TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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682  
66677  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH: a. COUNTY <b>HARFORD</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>HARFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harford Grace</b>		c. LENGTH OF STAY IN 1b <b>54 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Baby Boy</b> First Middle Last <b>CASSILLY</b>		4. DATE OF DEATH <b>JANUARY 25 1961</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-23-61</b>
9. AGE (In years last birthday) <b>0</b> yrs.		10. IF UNDER 1 YEAR: Months <b>2</b> Days <b>2</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Richard Robert Cassilly</b>		14. MOTHER'S MAIDEN NAME <b>Helen Koliopolous</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Richard Cassilly</b> Address <b>Aberdeen Maryland.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>773.0</b> IMMEDIATE CAUSE (a) <b>Respiratory failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <b>Hyaline membranous disease</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 23</b> , 19 <b>61</b> , to <b>Jan 25</b> , 19 <b>61</b> , that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at <b>8:55</b> A. M. from the causes and on the date stated above.			
22a. SIGNATURE <b>R. Normmet</b>		22b. DATE SIGNED <b>1-25-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. Normmet</b>		22d. ADDRESS <b>Havre de Grace Maryland.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 26, 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>St. Francis</b>		23d. LOCATION (City, town, or county) (State) <b>Abingdon, Harford, Maryland.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard W. Brown</b>		25a. REC'D BY REGISTRAR <b>JAN 30 '61</b> ADDRESS <b>Abingdon, Md.,</b>	
		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

2071317XV3

CERTIFICATE OF MARRIAGE

1961

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*

Witnessed by: \_\_\_\_\_  
Date: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Signature: \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

683

## CERTIFICATE OF DEATH

Reg. Dist. No.

00678

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen (Rural)</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D. #2, 3</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>SUSAN</b> Middle <b>WARFIELD</b> Last <b>CHRISTY</b>				4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>19 61</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 15, 1861</b>			
9. AGE (In years last birthday) yrs. <b>99</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>*** **</b>		17. INFORMANT Address <b>Florence Presbury, RD. 2, Aberdeen, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Renal Insufficiency</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <b>114</b> , 19 <b>61</b> , to <b>1122</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>1121</b> , 19 <b>61</b> , and that death occurred at <b>1:05 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>569 Revolution St.</b> DATE SIGNED <b>1/24/61</b> ACTUAL SIGNATURE <b>George T. Stansbury</b> M.D. PHYSICIAN'S NAME (Type) <b>George T. Stansbury, M.D.</b> <b>Havre de Grace, Md.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/25/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union M.E. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>R.D. #2, Aberdeen, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Barring</b> <b>Tarring Funeral Home</b> <b>Aberdeen, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 30 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneave</b>			

CERTIFICATE OF DEATH

DECEASED NAME (Print or Write)		SEX (Male or Female)	
AGE (Years, Months, Days)		DATE OF BIRTH (Month, Day, Year)	
PLACE OF BIRTH (City, State, Country)		PLACE OF DEATH (City, State, Country)	
OCCUPATION (If any)		CAUSE OF DEATH (If known)	
MANNER OF DEATH (If known)		PERIOD OF ILLNESS (If known)	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESS (If known)	
SIGNATURE OF PHYSICIAN (If known)		SIGNATURE OF CORONER (If known)	
SIGNATURE OF JUDGE (If known)		SIGNATURE OF CLERK (If known)	

10-10-10



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00679

<p>1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u></p>			
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL Air (Rural)</u></p>		<p>c. LENGTH OF STAY IN 1b <u>LIFE</u></p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BEL Air (Rural)</u></p>			
<p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Thomas Run Road</u></p>				<p>d. STREET ADDRESS <u>Thomas Run Road</u></p>		<p>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES A. CORNS</u></p>				<p>4. DATE OF DEATH Month Day Year <u>JANUARY 27, 1961</u></p>			
<p>5. SEX <u>MALE</u></p>		<p>6. COLOR OR RACE <u>NEGRO</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>April 5, 1881</u></p>	
<p>9. AGE (In years last birthday) <u>79</u> yrs.</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>		<p>13. FATHER'S NAME <u>ALEXANDER CORNS</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>JENNIE PRIGG</u></p>			
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO. <u>215-36-8368</u></p>		<p>17. INFORMANT (Wife) <u>Mrs. HANNA RUMSEY CORNS</u> Address <u>Rd Route #1, Box 389 BEL Air, Maryland</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) _____ DUE TO (c) _____</p>							<p>INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u></p>
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>							
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)</p>		<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19</p>		<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work</p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I attended the deceased from <u>1946</u> to <u>JAN. 27, 1961</u>, that I last saw the deceased alive on <u>Nov. 14, 1960</u>, and that death occurred at <u>11:50 A.M.</u> from the causes and on the date stated above.</p>							
<p>ACTUAL SIGNATURE <u>Charles Richardson, Jr.</u> M.D.</p>		<p>ADDRESS (Street, city or town, state) <u>126 S. Main Belli, Md</u> DATE SIGNED <u>1/28/61</u></p>					
<p>PHYSICIAN'S NAME (Type) <u>Charles Richardson, Jr.</u></p>							
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>22b. DATE THEREOF <u>JAN. 30, 1961</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>CLARK'S Chapel Cem.</u></p>		<p>22d. LOCATION (City, town, or county) (State) <u>BEL Air Rural, Harford Co., Maryland</u></p>	
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> ADDRESS <u>W. Broadway &amp; W. Williams St., BEL Air, Maryland</u></p>				<p>24a. REC'D BY REGISTRAR <u>JAN 31 '61</u></p>		<p>24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u></p>	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

RETAIN BOND

DECEASED		DATE OF DEATH	
NAME		SEX	
AGE		RACE	
BIRTH DATE		BIRTH PLACE	
MARRIED		MARRIED	
OCCUPATION		OCCUPATION	
EDUCATION		EDUCATION	
RELIGION		RELIGION	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
DATE OF DEATH		DATE OF DEATH	
TIME OF DEATH		TIME OF DEATH	
SIGNATURE		SIGNATURE	
DATE		DATE	
PLACE		PLACE	
NAME		NAME	
ADDRESS		ADDRESS	
CITY		CITY	
STATE		STATE	
ZIP		ZIP	

685

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00680

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John (Johnny)</u> Middle <u>Lee</u> Last <u>Daily</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1919</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>11</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Alderbrook Nursing Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Daily</u>		14. MOTHER'S MAIDEN NAME <u>Daisy Mae (Kenny) Daily</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War II</u>		16. SOCIAL SECURITY NO. <u>421-16-6009</u>	
17. INFORMANT <u>Mrs. Mary E. Daily, Havre de Grace, Md.</u>		Address <u>801 Garfield Road</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>603X Uremia</u> DUE TO (b) <u>Malignant Hypertension</u> DUE TO (c) <u>Renal Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/6</u> 19 <u>61</u> , to <u>1/21</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/21</u> 19 <u>61</u> , and that death occurred on <u>1/21</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>George T. Stansbury</u>		22b. DATE SIGNED <u>1/21/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		22d. ADDRESS <u>569 Revolution St. Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-27-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Bullock</u>		25a. REC'D BY REGISTRAR <u>DATE</u> <u>JAN 25 '61</u>	
ADDRESS <u>Havre de Grace, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Place of birth: [illegible]  
6. Date of death: [illegible]  
7. Place of death: [illegible]  
8. Cause of death: [illegible]  
9. Manner of death: [illegible]  
10. Signature of physician: [illegible]  
11. Signature of registrar: [illegible]  
12. Date of registration: [illegible]

RECEIVED  
FEB 10 1910

686 **CERTIFICATE OF DEATH** 00681

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY IN 1b <u>9 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Havre de Grace</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				d. STREET ADDRESS <u>P.O. Box 13 (Old Bay Farm)</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>R.</u> Last <u>Dever</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 15, 1894</u>	
9. AGE (In years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>		IF UNDER 24 HRS. Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min. <u>66</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Robinson</u>				14. MOTHER'S MAIDEN NAME <u>Alice T. (Barwick) Robinson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Chas. Dever</u> Address <u>old Bay Farm</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>181.0</u> DUE TO <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chondrosarcoma Bladder</u> DUE TO <u>1 year</u> (c) <u>4 day</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/24/61</u> to <u>1/27/61</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>1/27/61</u> , and that death occurred on <u>1/27/61</u> at <u>1:30</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Ann H. Wachsman</u>				22b. DATE SIGNED <u>1/27/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Ann H. Wachsman</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/30/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bakers</u>		23d. LOCATION (City, town, or county) (State) <u>Abertown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Princess Dr. Hand Shaw, Md</u>				25a. REC'D BY REGISTRAR <u>DATE JAN 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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CERTIFICATE OF DEATH

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*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 4-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

687

## CERTIFICATE OF DEATH

00682

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Hartford</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Hartford</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>BEL AIR Md</u>		LENGTH OF STAY (In this place) <u>15 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR Md</u>			
TOWN				STREET ADDRESS (If rural give location) <u>BEL AIR Road</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BEL AIR Road</u>							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>CARL PAUL ECKELT</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>JAN 19 1961</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>MARRIED</u>	<b>8. DATE OF BIRTH</b> <u>Oct 17-1887</u>		<b>9. AGE last birthday</b> <u>73</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Poultry Farm</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Germany</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>US</u>	
<b>13. FATHER'S NAME</b> <u>UNKNOWN</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, No or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>218-10-8351</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>CARL ECKELT Joppa Md Box 315 RD 1</u>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>332X IMMEDIATE CAUSE (A)</b> <u>CARDIO-RESPIRATORY FAILURE</u>						<u>1 WEEK</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> <u>CEREBRAL THROMBOSIS</u>						<u>2 WEEKS</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO</b>							
<b>STATING UNDERLYING CAUSE LAST. (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <b>While at work</b> <input type="checkbox"/> <b>Not while at work</b> <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>1953</u> , to <u>17 JAN</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>17 JAN</u> , 19 <u>61</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>J. P. Adkins</u>				<b>ADDRESS</b> (Street, city, town, state) <u>401 Franklin Rd Bel Air Md 21014</u>		<b>DATE SIGNED</b> <u>JAN 20 1961</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>JAN 21/61</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>BEL AIR MEMORIAL GARDENS</u>		<b>LOCATION</b> (City, town, or county) (State) <u>BEL AIR Hartford Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph L. L. Bel Air Md</u>			
<b>DATE</b> <u>JAN 23 '61</u>							

# CERTIFICATE OF DEATH

881

Reg. Dist. No.

A. HUSBAND, WIFE, OR OTHER PERSON OF DECEASED

B. PLACE OF DEATH

DECEASED

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

INTERMEDIATE CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

TRAUMA

POISONING

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

OTHER

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

INTERMEDIATE CAUSE

PRE-EXISTING DISEASE

ACUTE DISEASE

CHRONIC DISEASE

TRAUMA

POISONING

INFECTIOUS DISEASE

NON-INFECTIOUS DISEASE

OTHER

REGISTRATION NO. MARYLAND DEPARTMENT OF HEALTH

THIS CERTIFICATE OF DEATH IS A STATUTORY REQUIREMENT OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS TO BE COMPLETED BY THE PHYSICIAN WHO ATTENDS THE DECEASED, OR BY THE CORONER OR JURY IN CASE OF SUICIDE, ACCIDENT, OR UNNATURAL DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND, WITHIN TEN DAYS OF THE DATE OF DEATH. IT IS TO BE MAINTAINED AS A PERMANENT RECORD.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00683

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Aberdeen</u>	
3. NAME OF DECEASED (Type or print) <u>David Brown Ellicott</u>		d. STREET ADDRESS <u>Box 299</u>	
4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Dec 27 1895</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tower Operator Aberdeen Proving Ground Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>C. Lewis Ellicott</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Thompson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>World War 1</u>		16. SOCIAL SECURITY NO. <u>212-18-0433</u>	
17. INFORMANT <u>Mrs. Francis Silvery</u>		Address <u>Darlington, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA of Stomach with</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>metastasis to liver and lungs</u> (c) <u>6 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 14</u> 19 <u>60</u> to <u>Jan. 6</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 5</u> 19 <u>61</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Dudley Phillips MD</u>		22b. DATE SIGNED <u>1/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u>		22d. ADDRESS <u>Darlington, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Jan 9, 1960</u>		23b. DATE THEREOF <u>Harford Co, MD</u>	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u>		25a. REC'D BY REGISTRAR <u>Jan 13 '61</u>	
ADDRESS <u>Darlington Md</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

689

**CERTIFICATE OF DEATH**

00684

1. PLACE OF DEATH o. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARVE DE GRACE</b>		c. LENGTH OF STAY IN 1b <b>5 HRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HARVE DE GRACE</b>		24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HARFORD MEMORIAL HOSP.</b>				d. STREET ADDRESS <b>MARYLAND AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>OTTO</b> First <b>RAYMOND</b> Middle <b>FREED</b> Last				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>25</b> Year <b>1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-12-1900</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FELIX FREED</b>				14. MOTHER'S MAIDEN NAME <b>FANNIE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Felix Freed - son</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>443X</b> IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular disease</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b>  <b>&gt; 5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <b>1-24-61</b> to <b>1-25-61</b> , that (I) (we) last saw the deceased alive on <b>1-25-61</b> , and that death occurred at <b>3:55</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>D. J. Plunkett Jr.</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>1/25/61</b>	
22c. PHYSICIAN'S NAME (Type) <b>D. J. Plunkett Jr.</b>				22d. ADDRESS <b>Harve de Grace Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-27-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hebrew Friendship</b>		23d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John Lewis</b>				25. REC'D BY REGISTRAR <b>JAN 27 1961</b>		25b. REGISTRAR'S SIGNATURE <b>William S. Evans</b>	

MEDICAL CERTIFICATION

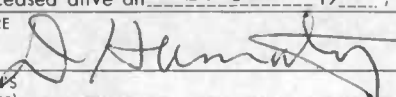





**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

690

00685

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>			c. LENGTH OF STAY IN 1b <b>6½ hours</b>			d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>32 Bel Air</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. ARMY HOSPITAL Aberdeen Proving Ground, Md.</b>				d. STREET ADDRESS <b>5 Dixie Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FREDERICK</b> Middle <b>WILLIAM</b> Last <b>GERHARD</b>				4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>26 Oct 1896</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier-Retired Colonel</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army (Retired)</b>		11. BIRTHPLACE (State or foreign country) <b>South Dakota</b>	
13. FATHER'S NAME <b>Fredrick William Gerhard</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Powers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1915-1954</b>		17. INFORMANT <b>Helen C. Gerhard, 5 Dixie Avenue, Bel Air, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.0</b> IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Arteriosclerotic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 Hours</b> <b>48 Hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive vascular disease, Pulmonary edema</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>43</b> (this hospital) attended the deceased from <b>24 Jan 1961</b> to <b>24 Jan 1961</b> , that <b>xx</b> (we) last saw the deceased alive on <b>24 Jan 1961</b> , and that death occurred at <b>6:20 P.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE <b>24 January 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>D. HAMATY, Captain, MC</b>				22d. ADDRESS <b>U.S. Army Hospital, Aberdeen Proving Ground, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-27-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Arlington, Va</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Road</b>				25a. REC'D BY REGISTRAR DATE <b>JAN 27 '61</b>		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any dissection is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

FOR STATE  
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

691 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00686

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Street</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Street rural</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>(John) Jack</u> Middle Last		4. DATE OF DEATH <u>January 29</u> 19 <u>61</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-26-83</u> 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>KENNELMAN RETIRED HARFORD HUNT CLUB</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
13. FATHER'S NAME <u>Not known</u>		14. MOTHER'S MAIDEN NAME <u>not known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-22-1755</u>	
17. INFORMANT <u>Mrs Victor Barrow, 902 Southerly Rd., Towson, Md.</u> Address		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>1-29-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb 1st 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St James Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Monkton, Baltimore Co. Md.</u>	
23. FUNERAL DIRECTOR <u>Martin H. Kurtz, Jarrettsville, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>FEB 2 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

FOR STATE  
HEALTH DEPT

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QUALITY IMPROVEMENT  
PROGRAM

1  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 692  
 CERTIFICATE OF DEATH  
 00687

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HARFORD</u>				c. LENGTH OF STAY IN 1b <u>23 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>HALLOWAY</u> Last			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>16</u> Year <u>1961</u>				
5. SEX <u>female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 15, 1961</u>		9. AGE (In years last birthday) yrs. <u>23</u>	IF UNDER 1 YEAR Months <u>23</u> Days <u>23</u>	IF UNDER 24 HRS. <u>23</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>HARFORD, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Halloway</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA WALTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>HENRY HALLOWAY, DARLINGTON, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Genbro / Anoxia Punctura. Spont.</u> <u>761.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Placenta</u> DUE TO (c) <u>Punctura ty.</u> INTERVAL BETWEEN ONSET AND DEATH <u>23 hrs.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-15</u> 19 <u>61</u> , to <u>1-16</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan 16</u> 19 <u>61</u> , and that death occurred at <u>8</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/16/61</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>1-17-1961</u>		<u>DARLINGTON Cemetery</u>		<u>DARLINGTON, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u>				ADDRESS <u>DELTA, PA.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 18 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

2071262XVI

CERTIFICATE OF DEATH

100

1. Name of deceased: John William  
2. Sex: Male  
3. Age: 45  
4. Date of birth: Jan 15 1880  
5. Place of birth: Worcester, Mass.  
6. Usual residence: 123 Main St. Boston  
7. Cause of death: Heart Disease  
8. Date of death: Jan 25 1925  
9. Place of death: Home  
10. Signature of physician: Dr. J. W. Smith  
11. Signature of registrar: John Doe

RECEIVED

DEPT. OF HEALTH

BOSTON

FILED



## 694

1. PLACE OF DEATH a. COUNTY <b>Hafford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital, Aberdeen Proving Ground, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>EDWARD</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>January</b> Day <b>22</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 22, 1961</b>
9. AGE (In years lost birthday) yrs. <b>—</b>		10. IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>	
11. IF UNDER 24 HRS. Hours <b>3</b> Min. <b>5</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>—</b>	
13. FATHER'S NAME <b>Robert M. Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Erika A. Klausnitzer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Father</b>		Address <b>17 Armstrong Street Edgewood, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe prematurity</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>776X</b> DUE TO (c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State) <b>—</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>4:55 A.M. 22 Jan 61</b> to <b>7:50 AM 22 Jan 61</b> , that (I) <b>we</b> lost saw the deceased alive on <b>22 January 19 61</b> , and that death occurred at <b>7:55 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>MALCOLM McLEAN, Capt, MC</b>		22b. DATE <b>22 January 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>MALCOLM McLEAN, Capt, MC</b>		22d. ADDRESS <b>U.S. Army Hospital Aberdeen Proving Ground, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Jan. 23rd 1961</b>		23b. DATE THEREOF <b>Jan. 23rd 1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Anatomy Board</b>		23d. LOCATION (City, town, or county) (State) <b>University of Md. Balt. and</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Harrington - Aberdeen. Md.</b>		25. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 693 CERTIFICATE OF DEATH

Reg. Dist. No.

00689

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="margin-left: 100px;">Harford</span> <span style="margin-left: 100px;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="margin-left: 100px;">Maryland</span> <span style="margin-left: 100px;">b. COUNTY Harford</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 100px;">Bel Air</span>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="margin-left: 100px;">Bel Air</span>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <span style="margin-left: 100px;">Moore's Mill Road</span>				d. STREET ADDRESS <span style="margin-left: 100px;">Moore's Mill Road</span>			
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="margin-left: 100px;">Edith</span> Middle <span style="margin-left: 100px;">Edwards</span> Last <span style="margin-left: 100px;">Johnston</span>				<b>4. DATE OF DEATH</b> Month <span style="margin-left: 100px;">January</span> Day <span style="margin-left: 100px;">7</span> Year <span style="margin-left: 100px;">1961</span>			
5. SEX <span style="margin-left: 100px;">F</span>		6. COLOR OR RACE <span style="margin-left: 100px;">W</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="margin-left: 100px;">Oct. 17, 1893</span>	
9. AGE (In years last birthday) <span style="margin-left: 100px;">67 yrs.</span>		IF UNDER 1 YEAR Months <span style="margin-left: 100px;"></span> Days <span style="margin-left: 100px;"></span> Hours <span style="margin-left: 100px;"></span> Min. <span style="margin-left: 100px;"></span>		IF UNDER 24 HRS. Hours <span style="margin-left: 100px;"></span> Min. <span style="margin-left: 100px;"></span>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="margin-left: 100px;">secretary</span>				10b. KIND OF BUSINESS OR INDUSTRY <span style="margin-left: 100px;">-</span>		11. BIRTHPLACE (State or foreign country) <span style="margin-left: 100px;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="margin-left: 100px;">USA</span>				13. FATHER'S NAME <span style="margin-left: 100px;">William Lee Johnston</span>			
14. MOTHER'S MAIDEN NAME <span style="margin-left: 100px;">Mary Blake</span>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <span style="margin-left: 100px;">no</span> (If yes, give war or dates of service) <span style="margin-left: 100px;">-</span>			
16. SOCIAL SECURITY NO. <span style="margin-left: 100px;">212-67-7624</span>				17. INFORMANT <span style="margin-left: 100px;">Dr. Hammond Johnston</span> Address <span style="margin-left: 100px;">Bel Air, Md.</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <span style="margin-left: 100px;">Cerebral hemorrhage</span> DUE TO <span style="margin-left: 100px;">422.1</span> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <span style="margin-left: 100px;">Arteriosclerotic cardiovascular disease</span> DUE TO (c) <span style="margin-left: 100px;"></span> INTERVAL BETWEEN ONSET AND DEATH <span style="margin-left: 100px;">1 day</span> 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <span style="margin-left: 100px;">Residual paralysis from previous cerebral thrombosis</span>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <span style="margin-left: 100px;">19</span> p. m. <span style="margin-left: 100px;"></span>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <span style="margin-left: 100px;">October 1955</span> to <span style="margin-left: 100px;">January 7, 1961</span> , that I last saw the deceased alive on <span style="margin-left: 100px;">January 7, 1961</span> , and that death occurred at <span style="margin-left: 100px;">9:40 M.</span> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <span style="margin-left: 100px;">115 Fulford Ave., Bel Air, Md.</span> DATE SIGNED <span style="margin-left: 100px;">1/8/60</span>							
ACTUAL SIGNATURE <span style="margin-left: 100px;">Paul S. Stonesifer, Jr.</span> M.D.				PHYSICIAN'S NAME (Type) <span style="margin-left: 100px;">Paul S. Stonesifer, Jr., M. D.</span>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <span style="margin-left: 100px;">Burial</span>		22b. DATE THEREOF <span style="margin-left: 100px;">1/10/61</span>		22c. NAME OF CEMETERY OR CREMATORY <span style="margin-left: 100px;">Woodlawn</span>		22d. LOCATION (City, town, or county) (State) <span style="margin-left: 100px;">Woodlawn, Maryland</span>	
23. FUNERAL DIRECTOR'S SIGNATURE <span style="margin-left: 100px;">J. J. Tackner &amp; Sons</span> ADDRESS <span style="margin-left: 100px;">Baltimore 17 Md.</span>				24a. REC'D BY REGISTRAR <span style="margin-left: 100px;">DATE JAN 9 '61</span>			
24b. REGISTRAR'S SIGNATURE <span style="margin-left: 100px;">D. L. Kline</span>				24c. REGISTRAR'S SIGNATURE			

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 695 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00690**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>31 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>Robert Hood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Leo F Kerns</u> First Middle Last		<b>4. DATE OF DEATH</b> <u>January 21 1961</u> Month Day Year		<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1-2-88</u> <b>9. AGE</b> (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Abundant Property Account</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Martinsburg W. Va.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>		<b>13. FATHER'S NAME</b> <u>Augustus Kerns</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Geneva Mouse</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>WW I</u> <b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u> <b>17. INFORMANT</b> <u>Rose W. Kerns</u> Address <u>Robin Hood Road Harford Co. Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>Gerald C Palmer</u> <b>EXAMINER'S NAME (Type)</b> <u>Gerald C Palmer</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> DATE SIGNED <u>1-22-61</u>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>22b. DATE THEREOF</b> <u>1/24/61</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Angel Hill</u>			
<b>22d. LOCATION (City, town or county) (State)</b> <u>Harford County Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Prington &amp; Son, Harford County, Md</u>					
<b>24a. REC'D BY REGISTRAR</b> <u>JAN 24 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hanna</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]	
AGE [Faint handwritten age]		RACE [Faint handwritten race]	
DATE OF DEATH [Faint handwritten date]		TIME OF DEATH [Faint handwritten time]	
PLACE OF DEATH [Faint handwritten address]		CITY [Faint handwritten city]	
COUNTY [Faint handwritten county]		STATE [Faint handwritten state]	
OCCUPATION [Faint handwritten occupation]		CAUSE OF DEATH [Faint handwritten cause]	
MANNER OF DEATH [Faint handwritten manner]		MEDICAL HISTORY [Faint handwritten medical history]	
PREVIOUS ILLNESS [Faint handwritten previous illness]		SURGICAL HISTORY [Faint handwritten surgical history]	
MEDICATION [Faint handwritten medication]		TREATMENT [Faint handwritten treatment]	
SIGNATURE OF EXAMINER [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]	
OFFICIAL SEAL [Faint official seal]		OFFICIAL SEAL [Faint official seal]	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

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696

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00691

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAVRE DE GRACE</b>				c. LENGTH OF STAY IN 1b <b>5 YRS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>669 REVOLUTION ST.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>MATTIE</b> First <b>TOUHEY</b> Middle <b>KIMBALL</b> Last				4. DATE OF DEATH <b>JAN 29 1961</b> Month <b>JAN</b> Day <b>29</b> Year <b>1961</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 11, 1880</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>JAMES H. SHOOK</b>				14. MOTHER'S MAIDEN NAME <b>NINEVAH M.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>DANIEL F. KIMBALL</b> Address <b>HAVRE DE GRACE MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Turned off chest probably malignant</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1/28</b> 19 <b>61</b> to <b>Jan 29, 1961</b> , that (I) (we) last saw the deceased alive on <b>1/28</b> 19 <b>61</b> , and that death occurred at <b>7:25</b> AM, from the causes and on the date stated above.							
22a. SIGNATURE <b>A. L. Lewis MD</b>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <b>A. L. Lewis MD</b>	
22d. ADDRESS <b>Havre de Grace MD</b>				22e. MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>FEB. 1, 1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT OLIVE CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>BALTIMORE CO. MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>R. Madison Mitchell</b> ADDRESS <b>HAVRE DE GRACE MD</b>				25a. REC'D BY REGISTRAR <b>FEB 1 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kross</b>	

CERTIFICATE OF DEATH

696

DANIEL F. KIMBALL

JAMES F. KIMBALL

James F. Kimball

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00692

697

1. PLACE OF DEATH o. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Bel Air</b>				c. LENGTH OF STAY IN 1b <b>5 years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural, Forest Hill,</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Convalescent Home</b>			
d. STREET ADDRESS <b>Greer Nursery Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Reynolds</b> Last <b>Lackey</b>				4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>1961</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 1880</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter (Retired)</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Henry Lackey</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Bunce</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>111-111111</b>		17. INFORMANT Address <b>Harford Convalescent Home, Bel Air, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c) <b>Chronic Cardio-vascular Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>I ?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 10, 1939</b> , to <b>January 13, 1961</b> , that I last saw the deceased alive on <b>January 5, 1961</b> , and that death occurred at <b>5:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Willard P. Hudson</b> M.D.				ADDRESS (Street, city or town, state) <b>Forest Hill, Md.</b> DATE SIGNED <b>January 13, 1961</b>			
PHYSICIAN'S NAME (Type) <b>Willard P. Hudson, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 14/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rock Spring</b>		22d. LOCATION (City, town, or county) (State) <b>Forest Hill, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph T. Foster</b> ADDRESS <b>Bel Air, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JAN 17 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 698 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **00693**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Harford Memorial Hospital</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> d. STREET ADDRESS <u>Gravel Hill</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>Nelson J Lee</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>January 12 1961</u> Month Day Year		
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>C</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>July 4, 1898</u>		<b>9. AGE</b> (In years last birthday) <u>62 yrs.</u> IF UNDER 1 YEAR: Months <u>6</u> Days <u>8</u> IF UNDER 24 HRS.: Hours <u>8</u> Min. <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Contractor</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Harford County, Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>			<b>13. FATHER'S NAME</b> <u>Nelson A. Lee</u>		
<b>14. MOTHER'S MAIDEN NAME</b> <u>Hannah Lee</u>			<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		
<b>16. SOCIAL SECURITY NO.</b> <u>-</u>			<b>17. INFORMANT</b> <u>Mrs. Laura L. Dorsey - Atudeen, Md.</u> Address <u>36 Baltimore St.</u>		
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> <u>812X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture R femur</u>					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH.</b> <input checked="" type="checkbox"/>			
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Pedestrian - Auto</u>		<b>20c. TIME OF INJURY</b> Month, Day, Year <u>1-12-61</u> Hour <u>5</u> p.m. <u>1-12</u>			
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Rte. 155</u>		<b>20f. (City or town) (County) (State)</b> <u>Harre de Grace Harford Md</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
<b>ACTUAL SIGNATURE</b> <u>Gerald C Palmer</u> <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <u>1-13-61</u> <b>EXAMINER'S NAME (Type)</b> <u>Gerald C Palmer - M.D.</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>					
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>Jan. 17, 1961</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Greenspring Cemetery</u>	
<b>22d. LOCATION (City, town, or county) (State)</b> <u>Harford County, Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Elmer E. Bullock</u> <b>ADDRESS</b> <u>Harre de Grace, Md</u>			
<b>24a. REC'D BY REGISTRAR</b> <u>JAN 19 '61</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7:59

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6694

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>York</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bel Air</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>York</b>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <b>75X-3</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>211 S. Main St.</b>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Brenda Lee Lewis</b>		First Middle Last		4. DATE OF DEATH <b>January 28 1961</b>		Month Day Year	
5. SEX <b>female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 12 - 1960</b>	
9. AGE (in years last birthday) <b>5 yrs.</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>York, Pa</b>	
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>Ava Lewis</b>		14. MOTHER'S MARDEN NAME <b>Rachel Cochran</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service) <b>None</b>	
16. SOCIAL SECURITY NO. <b>631 BIRNLEE ST, YORK, Pa</b>		17. INFORMANT <b>Ava Lewis</b>		Address <b>631 BIRNLEE ST, YORK, Pa</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonitis</b> 391.2 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Bilateral Otitis Media</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	
21. ACTUAL SIGNATURE <b>Charles S. Petty</b>		21. EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		21. M.D. <b>Charles S. Petty</b>		21. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
21. DATE SIGNED <b>1/29/61</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 31/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SPARON Baptist</b>	
22d. LOCATION (City, town, or country) (State) <b>Forest Hill Harford Md</b>		22e. REC'D BY REGISTRAR <b>Joseph J. Ladd</b>		22f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		22g. DATE <b>JAN 31 '61</b>	

MEDICAL CERTIFICATION

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DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
OCCUPATION: [illegible]  
CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
TIME OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]

*[Handwritten signature]*  
*[Handwritten text]*

1

DATE: [illegible]  
TIME: [illegible]  
PLACE: [illegible]  
MANNER: [illegible]

DEATH CERTIFICATE  
[illegible text]

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
700

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00695

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Hartford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre-de-Grace</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lewis</u> First, <u>G</u> Middle, <u>Miller</u> Last				4. DATE OF DEATH Month <u>1</u> Day <u>15</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/6/1878</u>	
9. AGE (In years lost birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Abert L. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Matilda Wordell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT Address <u>Robert Miller, Rock Hall, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that (I) (this hospital) attended the deceased from <u>1/13/61</u> to <u>1/15/61</u> , that (I) (we) last saw the deceased alive on <u>1/15/61</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Wm. H. Waldman</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) <u>Wm. H. Waldman</u>				22d. ADDRESS <u>  </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>		23b. DATE THEREOF <u>1/18/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		23d. LOCATION (City, town, or county) (State) <u>Hartford Grace, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>  </u> ADDRESS <u>  </u>				25a. REC'D BY REGISTRAR DATE <u>JAN 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>  </u>	

AP

THE LAND OFFICE  
ALBANY, N. Y.  
JANUARY 1, 1900

TO THE SENATE

SIR:

I have the honor to acknowledge the receipt of your letter of the 27th inst., and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Your obedient servant,  
J. B. HARRIS,  
Commissioner of the Land Office.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **00696**

701

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Bel Air</b>		c. LENGTH OF STAY IN 1b <b>1 year</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harford Convalescent Home</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>L.</b> Last <b>Miller</b>		4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 23, 1870</b>
9. AGE (In years last birthday) <b>90 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Jarrettsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Hutchins Miller</b>		14. MOTHER'S MAIDEN NAME <b>Emma Barber</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>----</b>	
17. INFORMANT <b>Miss. Irene Miller</b>		Address <b>Bel Air, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Cardio-vascular Disease</b> DUE TO (c) <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 6, 1960</b> , to <b>January 27, 1961</b> , that I last saw the deceased alive on <b>January 26, 1961</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Forest Hill, Maryland</b> DATE SIGNED <b>January 28, 1961</b>			
ACTUAL SIGNATURE <b>Willard P. Hudson</b> M.D. <b>Forest Hill, Maryland</b> <b>January 28, 1961</b>			
PHYSICIAN'S NAME (Type) <b>Willard P. Hudson, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Jarrettsville</b>		22d. LOCATION (City, town, or county) (State) <b>Jarrettsville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Kurtz</b>		24a. REC'D BY REGISTRAR <b>JAN 31 '61</b>	
ADDRESS <b>Jarrettsville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VP AIS (4)  
15M 9/59

702  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00687

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>31</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		d. STREET ADDRESS <u>638 MARKET ST.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MORRISON</u>		4. DATE OF DEATH Month Day Year <u>JAN. 3 1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-61</u>
9. AGE (In years lost birthday) yrs. <u>7</u>		10. IF UNDER 1 YEAR Months Days <u>7</u> <u>31</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>DONALD MORRISON</u>		14. MOTHER'S MAIDEN NAME <u>JOAN F. BENTZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>          </u>	
17. INFORMANT <u>          </u>		Address <u>          </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>776X</u> IMMEDIATE CAUSE (a) <u>Prematurity</u> DUE TO (b) <u>          </u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) <u>          </u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>          </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>          </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-2</u> 19 <u>61</u> to <u>1-3</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>1-3</u> 19 <u>61</u> , and that death occurred at <u>2:58</u> P. M. from the causes and on the date stated above.			
22a. SIGNATURE <u>B. J. Plunkett Jr</u>		22b. DATE SIGNED <u>          </u>	
22c. PHYSICIAN'S NAME (Type) <u>          </u>		22d. ADDRESS <u>          </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>          </u>		23b. DATE THEREOF <u>1/3/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Harford Mem. Hosp.</u>		23d. LOCATION (City, town, or county) (State) <u>Havre de Grace, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry G. Hospital Administrator</u>		25a. REC'D BY REGISTRAR <u>          </u>	
25b. REGISTRAR'S SIGNATURE <u>          </u>		DATE <u>JAN 6 '61</u>	

2071241XVVO

# CERTIFICATE OF DEATH

50

<p>1. Name of deceased                  JAMES EARL RAY</p>		<p>2. Date of death                  APRIL 4, 1968</p>	
<p>3. Place of death                  MEMPHIS, TENNESSEE</p>		<p>4. Cause of death                  SHOOTING</p>	
<p>5. Name of physician                  DR. J. H. HARRIS</p>		<p>6. Name of funeral home                  JAMES EARL RAY FUNERAL HOME</p>	
<p>7. Name of next of kin                  MARY ELIZABETH RAY</p>		<p>8. Name of informant                  MARY ELIZABETH RAY</p>	
<p>9. Name of registrar                  JAMES EARL RAY</p>		<p>10. Name of witness                  JAMES EARL RAY</p>	

# 1 703 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00658

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>William C. Norris, Sr.</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>January 14, 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 19, 1903</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Calvin Norris</u>	
14. MOTHER'S MAIDEN NAME <u>Irene Ely</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 03 2988</u>		17. INFORMANT <u>William C. Norris, Jr., Forest Hill, Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Coronary Artery Disease (Arteriosclerosis)</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 14, 1961</u> to <u>Jan 14, 1961</u> , that I last saw the deceased alive on <u>Jan 14, 1961</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Willard P. Hudson, Forest Hill, Md. January 14, 1961</u>							
ACTUAL SIGNATURE <u>Willard P. Hudson</u>							
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/16/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Tabor</u>				24a. REC'D BY REGISTRAR <u>Bel Air</u>			
ADDRESS <u>Bel Air</u>				24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

103

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>NAME OF DECEASED <i>William J. Brown</i></p>		<p>DATE OF DEATH <i>July 15, 1945</i></p>	
<p>AGE <i>45</i></p>		<p>SEX <i>Male</i></p>	
<p>DATE OF BIRTH <i>July 15, 1900</i></p>		<p>PLACE OF BIRTH <i>St. Louis, Mo.</i></p>	
<p>RESIDENCE <i>1234 Main St., Baltimore, Md.</i></p>		<p>CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>DIAGNOSIS <i>Coronary Artery Disease</i></p>		<p>IMMEDIATE CAUSE OF DEATH <i>Myocardial Infarction</i></p>	
<p>PREVIOUS ILLNESS <i>None</i></p>		<p>PREVIOUS SURGERY <i>None</i></p>	
<p>DATE OF EXAMINATION <i>July 15, 1945</i></p>		<p>PLACE OF EXAMINATION <i>Home</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>John Doe, M.D.</i></p>		<p>SIGNATURE OF REGISTRAR <i>John Doe, M.D.</i></p>	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 10-15-2010 BY 60322 UCBAW/BK/STP

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG281 2-14-61 et

704

## CERTIFICATE OF DEATH

Reg. Dist. No.

00699

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>12 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home -- 250 Alliance Road</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> d. STREET ADDRESS <u>250 Alliance</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marie Willis Brem</u>				4. DATE OF DEATH <u>1/31/61</u> Month <u>1</u> Day <u>31</u> Year <u>19</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14-1899</u> yrs. <u>61</u>	
9. AGE (In years last birthday) <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		13. FATHER'S NAME <u>Henry D. Bullen</u>		14. MOTHER'S MAIDEN NAME <u>Lavinia Willis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mrs Ralph Robinson</u> Address <u>250 Alliance</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY Thrombosis &amp; Atherosclerotic Heart Disease</u> DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan 18</u> , 19 <u>61</u> , to <u>Jan 31</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan 18</u> , 19 <u>61</u> , and that death occurred at <u>4:00</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>355 Green St, Harford de Grace, Md.</u> DATE SIGNED <u></u>							
ACTUAL SIGNATURE <u>Frank D. Hauber</u>				M.D. <u>Frank D. Hauber, M. D.</u>			
PHYSICIAN'S NAME (Type) <u>Frank D. Hauber, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2/3/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford de Grace Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William P. M. Harford de Grace Md</u>				24a. REC'D BY REGISTRAR <u>FEB 7 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





**DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

705

60700

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>25 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X JOPPA</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DAVE R. OSBORNE SR.</u>				4. DATE OF DEATH Month Day Year <u>JAN. 28 1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1, 1921</u>		9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MECHANIC</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Richlands, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.,</u>	
13. FATHER'S NAME <u>DAVE OSBORNE SR.</u>				14. MOTHER'S MAIDEN NAME <u>VIRGINIA DYE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>WWII 232-24-8314</u>		17. INFORMANT <u>Mrs., Mamie Osborne</u>		Address <u>Joppa, Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis — Following</u> <u>587.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Surgery for internal drainage of</u> (c) <u>Pancreatic Cyst — Pulmonary Congestion 3 hrs</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NA</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JAN 3 1961</u> , to <u>JAN 28, 1961</u> , that (I) (we) last saw the deceased alive on <u>JAN. 28 1961</u> , and that death occurred at <u>3:42 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles E. Schoenhals MD</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1/28/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles E. Schoenhals MD</u>				22d. ADDRESS <u>1814 Glen Ridge Rd. Balt. 4, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan 31, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City, town, or county) (State) <u>Bel Air, Harford, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard L. McBrum</u>				ADDRESS <u>Abingdon, Md.,</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 1 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles E. Schoenhals</u>			

CERTIFICATE OF DEATH

705

DATE OF DEATH

1911

PLACE OF DEATH

HOME

1000

1911

CAUSE OF DEATH

HEART

1911

NAME OF DECEASED

JOHN

1911

AGE

45

1911

1911

SEX

MALE

1911

DATE

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44

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1911

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
706  
CERTIFICATE OF DEATH

00701

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve De Grace</u>				c. LENGTH OF STAY IN 1b <u>24 hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u> <u>07X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>Cecil Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>Pelagalli</u> Last <u>Pelagalli</u>				4. DATE OF DEATH Month <u>January</u> Day <u>15</u> Year <u>1961</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 21, 1889</u>			
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min. <u>15</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penna, R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-07-5526</u>		17. INFORMANT Address <u>Roland Rapposelli, Perryville, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) <u>212.9</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 14</u> , 19 <u>61</u> , to <u>Jan. 15</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Jan. 15</u> , 19 <u>61</u> , and that death occurred at <u>11</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Irvin Wachsman, M.D.</u>				22b. DATE SIGNED <u>Jan 15, 1961</u>					
22c. PHYSICIAN'S NAME (Type) <u>Irvin Wachsman, M.D.</u>				22d. ADDRESS <u>Harve De Grace, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-17-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Brookview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Rising Sun, Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lee A. Patterson &amp; Son</u>				ADDRESS <u>Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 17 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>					

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "State of New York" and "County of" are faintly visible.]*

*[Faint, mostly illegible text at the bottom of the page, likely bleed-through from the reverse side. Some words like "Witness my hand" and "Attest" are faintly visible.]*

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

707

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00702

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> <u>24</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>			d. STREET ADDRESS <u>623 Freedom Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Perkins</u>			4. DATE OF DEATH Month <u>1</u> Day <u>6</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-5-61</u>		9. AGE (In years lost birthday) yrs. <u>1</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Harre de Grace, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Willie Perkins</u>			14. MOTHER'S MAIDEN NAME <u>Sandra Brown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>623 Freedom St. Harre de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Atelectasis</u> 76220 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> , 19 <u>61</u> , to <u>1/6</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1/6</u> , 19 <u>61</u> , and that death occurred at <u>4:40 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>George T. Stansbury</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>		22d. ADDRESS <u>509 Revolution St Harre de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/9/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Reed Methodist Cemetery North East Cecil Md.</u>	
23d. LOCATION (City, town, or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Otelia J. Bullock</u>		ADDRESS <u>556 Paris St. Harre de Grace, Md.</u>		25a. RECEIVED BY REGISTRAR DATE <u>JAN 10 1961</u>	
25b. REGISTRAR'S SIGNATURE <u>Robert A. Perkins</u>					

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

**708**

**66703**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>HARFORD</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. STREET ADDRESS <u>Box 265</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Minnie</u> Middle <u>O.</u> Last <u>Pierce</u>				<b>4. DATE OF DEATH</b> Month <u>January</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 12, 1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>John P. Kammerer</u>				14. MOTHER'S MAIDEN NAME <u>Ernesta Ulrich</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>George F. Pierce, Joppa, Maryland</u> Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertensive Cardiovascular and</u> <u>Atherosclerotic Cardiovas. disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>  <u>3-4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 3, 1961</u> to <u>Jan. 6th, 1961</u> , that (I) (we) last saw the deceased alive on <u>JAN. 6, 1961</u> , and that death occurred at <u>12:45 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Loo</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				22d. ADDRESS <u>Harver de Grace, Ind.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 9, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran</u>		23d. LOCATION (City, town, or county) (State) <u>Joppa, Harford, Maryland.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard W. Burns Jr</u> ADDRESS <u>Abingdon, Md.,</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 11 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>	

State of Maryland  
County of Baltimore  
I, the undersigned, Clerk of the Circuit Court for the County of Baltimore, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said Court.

Witness my hand and the seal of said Court at Baltimore, Maryland, this 1st day of June, 1901.

John P. Knapton, Clerk of the Circuit Court for the County of Baltimore.  
George W. Ellice, Jr., Notary Public for the County of Baltimore.  
Jesse, Harlow, Maryland.  
Admission No. 11

709

## CERTIFICATE OF DEATH

Reg. Dist. No.

00704

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Abingdon</b>				c. LENGTH OF STAY IN 1b <b>42 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Pouska</b> Last <b>Pouska</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>7</b> Year <b>19 61</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July, 26, 1893</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Proprietor</b>		11. BIRTHPLACE (State or foreign country) <b>Czech</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.,</b>							
13. FATHER'S NAME <b>Alex Pouska</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-34-7472</b>		17. INFORMANT <b>Anna Pouska</b> Address <b>Abingdon Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypernephroma left Kidney with metastasis to liver, stomach &amp; other organs</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>6 mo +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <b>May</b> , 19 <b>54</b> , to <b>Jan</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Jan. 7</b> , 19 <b>61</b> , and that death occurred at <b>3:55</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William A. Tyson</b> M.D.				ADDRESS (Street, city or town, state) <b>Kingsville, Md.</b> DATE SIGNED <b>Jan. 9, 1961</b>			
PHYSICIAN'S NAME (Type) <b>William A. Tyson</b>				<b>Kingsville Md.,</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 11, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Francis</b>		22d. LOCATION (City, town, or county) (State) <b>Abingdon, Harford, Md.,</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard R. McCormick</b> ADDRESS <b>Abingdon Maryland.</b>				24a. REC'D BY REGISTRAR <b>JAN 13 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**THE UNIVERSITY OF CHICAGO**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00705

710

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Norrisville</b>		c. LENGTH OF STAY IN 1b <b>21yrs.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural Norrisville</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JEFF</b> Middle <b>PRICE</b> Last <b>PRICE</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>26</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 17, 1875</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Price</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Jane Spears</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>230-18-3826</b>	
17. INFORMANT <b>Mrs. Harry Alloway, Fawn Grove, RD, Penna.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE: <b>491X Broncho pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>general infirmities of old age</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL MEDICAL CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 14</b> , 19 <b>61</b> , to <b>Jan. 26</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Jan. 25</b> , 19 <b>61</b> , and that death occurred at <b>11:00</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Norman H. Gemmill</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Stewartstown, Pa. 1-26-61</b>	
PHYSICIAN'S NAME (Type) <b>Norman H. Gemmill</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial/Removal</b>		22b. DATE THEREOF <b>1-29-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>M't Olivet Meth. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Glade Springs, Wasn. Co., Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth A. Gibson</b>		ADDRESS <b>Stewartstown, Penna.</b>	
24a. REC'D BY REGISTRAR <b>Jan 30 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	







TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

711

00706

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY IN 1b <b>1 yr, 3 mos</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>US Army Hospital, Aberdeen Proving Ground, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RAFAEL</b> Middle <b>TORRES</b> Last <b>RIVERA</b>		4. DATE OF DEATH Month <b>January</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 29, 1938</b>
9. AGE (In years last birthday) <b>22</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>US Army</b>	
11. BIRTHPLACE (State or foreign country) <b>Puerto Rico</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown (Deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Unknown (Deceased)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Oct 59-Jan 61 581-66-8488</b>	
17. INFORMANT <b>US Army Official Records, Aberdeen Proving Ground, Md.</b>		Address <b>Headquarters,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Injuries, multiple, extreme</b> DUE TO <b>Being struck by train</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DOA</b> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Struck by Pennsy RR passenger train</b>	
20c. TIME OF INJURY Month, Day Year <b>9 a.m. Jan 28 61</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Pennsy RR Station</b>		20f. (City or town) <b>Aberdeen</b> (County) <b>Harford</b> (State) <b>Maryland</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>28 Jan 61</b> to <b>28 Jan 61</b> that (I) (we) lost saw the deceased alive on <b>DOA</b> 19, and that death occurred at <b>DOA</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>Jerome B. Bryant Jr.</b>		22b. DATE SIGNED <b>Jan 28, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>JEROME B. BRYANT JR., Lt. Col., MC Aberdeen Proving Ground, Maryland</b>		22d. ADDRESS <b>US Army Hospital,</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>2/2/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Puerto Rico Nat'l. Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>San Juan, Puerto Rico</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14,</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 6 '61</b>	
ADDRESS <b>Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	

CERTIFICATE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

712

## CERTIFICATE OF DEATH

Reg. Dist. No.

00707

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>		c. LENGTH OF STAY IN 1b <i>26 YEARS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Victory Lane</i>		d. STREET ADDRESS <i>1 Victory Lane</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Frank J Rutkowski</i>		4. DATE OF DEATH Month Day Year <i>January 3 1961</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 31, 1907</i>
9. AGE (In years last birthday) <i>53</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>U. S. Army</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U. S. Govt.</i>	
11. BIRTHPLACE (State or foreign country) <i>Scranton, Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Joseph Rutkowski</i>		14. MOTHER'S MAIDEN NAME <i>Catherine (Unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i> (If yes, give war or dates of service) <i>World War II</i>		16. SOCIAL SECURITY NO. <i>212-30-3564</i>	
17. INFORMANT (WIFE) <i>Mrs. Olive Noonan Rutkowski</i>		Address <i>207 Victory Lane Bel Air, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral embolus with left hemiplegia</i> 410X DUE TO <i>and old right hemiplegia secondary to previous cerebral embolism</i> (b) <i>Rheumatic heart disease with mitral stenosis and aortic valve calcification</i> DUE TO <i>chronic obstructive pulmonary disease</i> (c) <i>chronic obstructive pulmonary disease</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-3</i> , 19 <i>56</i> , to <i>1-3</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>1-3</i> , 19 <i>61</i> , and that death occurred at <i>6 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Gerald E Palmer</i>		ADDRESS (Street, city or town, state) <i>Bel Air, MD</i> DATE SIGNED <i>1-3-61</i>	
PHYSICIAN'S NAME (Type) <i>Gerald E Palmer MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 6, 1961</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial Gardens</i>		22d. LOCATION (City, town, or county) (State) <i>Bel Air, Harford Co., Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph W. Foster</i>		ADDRESS <i>W. Broadway + Williams St. Bel Air, Maryland</i>	
24a. REC'D BY REGISTRAR <i>DATE JAN 5 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
713 CERTIFICATE OF DEATH

60708

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Cecil</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haute de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hosp</u>		d. STREET ADDRESS <u>Broad</u> 07X2	
3. NAME OF DECEASED (Type or print) <u>Baby boy Salyer</u>		4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 9, 1961</u>
9. AGE (In years last birthday) yrs. <u>7</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>9</u> Hours <u>1</u> Min. <u>0</u>	11. IF UNDER 24 HRS. Months <u>7</u> Days <u>9</u> Hours <u>1</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Ismael Salyer</u>		14. MOTHER'S MAIDEN NAME <u>Madgline Bach</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>none</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Remoture</u> DUE TO <u>776x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>776x</u> DUE TO (c) <u>776x</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>776x</u>			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/9</u> 19 <u>61</u> to <u>1/9</u> 19 <u>61</u> that (we) last saw the deceased alive on <u>1/9</u> 19 <u>61</u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>James P. Elder</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>1/12/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Salyers</u>		23d. LOCATION (City, town, or county) (State) <u>Swampston Ky.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Swampston Ky. Harford Chev. Md.</u>		25a. REC'D BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>		DATE <u>JAN 11 '61</u>	

1000

115

1. Name of deceased  
2. Sex  
3. Age  
4. Date of birth  
5. Date of death  
6. Place of birth  
7. Cause of death  
8. Signature of physician  
9. Signature of registrar

1

10. Name of informant  
11. Address of informant  
12. Signature of informant  
13. Date of filing  
14. Signature of registrar



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1

714

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00709

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY IN 1b <b>55 min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital Aberdeen Proving Ground, Md</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KAREN</b> Middle <b>LYNN</b> Last <b>SANTANGELO</b>		4. DATE OF DEATH Month <b>January</b> Day <b>24</b> Year <b>19 61</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 24, 1961</b>
9. AGE (In years lost birthday) yrs. <b>55</b>		10. IF UNDER 1 YEAR Months Days Hours Min <b>55</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dominick Rocco Santangelo</b>		14. MOTHER'S MAIDEN NAME <b>Pamela Lydia Rees</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Father</b>		Address <b>22 Cedar Street (north) Edgewood, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>776x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>55 min</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>it</b> (this hospital) attended the deceased from <b>January 24, 19 61</b> to <b>January 24, 19 61</b> that <b>it</b> (we) last saw the deceased alive on <b>January 24, 19 61</b> , and that death occurred at <b>920M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Malcolm McLean</b> M.D.		22b. DATE SIGNED <b>Jan 24, 1961</b>	
22c. PHYSICIAN'S NAME (Type) <b>MALCOLM MCLEAN CAPT MC</b>		22d. ADDRESS <b>US Army Hospital Aberdeen Proving Ground, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 26/1961</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Post Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Army Chemical Center. Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Barring - Aberdeen. Md.</b>		25a. REC'D BY REGISTRAR <b>JAN 30 61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>		DATE	

2050281XVO

CERTIFICATE OF DEATH

111

1. Name of the deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Place of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Signature of the attending physician: \_\_\_\_\_

10. Signature of the registrar: \_\_\_\_\_

11. Signature of the witness: \_\_\_\_\_

12. Signature of the coroner: \_\_\_\_\_

13. Signature of the police officer: \_\_\_\_\_

14. Signature of the health officer: \_\_\_\_\_

15. Signature of the veterinarian: \_\_\_\_\_

16. Signature of the judge: \_\_\_\_\_

17. Signature of the mayor: \_\_\_\_\_

18. Signature of the governor: \_\_\_\_\_

19. Signature of the president: \_\_\_\_\_

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

715 Item 13-211M6279 1-13-61 et  
**CERTIFICATE OF DEATH**

00710

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>24 Havre De Grace</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U S Army Hospital Aberdeen Proving Ground, Maryland</b>				d. STREET ADDRESS <b>327 Wilson Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>VICTOR</b> Last <b>SAVAGE</b>				4. DATE OF DEATH Month <b>January</b> Day <b>3</b> Year <b>1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 3, 1914</b>	
9. AGE (In years last birthday) <b>46 yrs.</b>		IF UNDER 1 YEAR Months <b>46</b> Days <b>46</b>		IF UNDER 24 HRS. Hours <b>46</b> Min. <b>46</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier SFC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Army</b>		11. BIRTHPLACE (State or foreign country) <b>Marklaysburg, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>(Deceased) Eli Savage</b>				14. MOTHER'S MAIDEN NAME <b>Minnie V. Nicklow</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>July 1942 to 206-01-0702</b>		17. INFORMANT <b>Official US Army Records, Aberdeen Proving Gr</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>54000</b> <b>GASTRIC HEMORRHAGE (MASSIVE)</b> <b>Dissecting Aortic Aneurysm</b> DUE TO (b) <b>Unknown GASTRIC ULCER, PERFORATION (?)</b> DUE TO (c) <b>Unknown</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <b>Undet</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>January 2, 1961</b> to <b>January 3, 1961</b> , that (I) (we) last saw the deceased alive on <b>January 3, 1961</b> , and that death occurred at <b>9:55 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Joseph A Grossman</b>				22b. DATE <b>3 January 1961</b>			
22c. PHYSICIAN'S NAME (Type) <b>JOSEPH A GROSSMAN, CAPT, MC</b>				22d. ADDRESS <b>US ARMY HOSPITAL, Aberdeen PG, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE THEREOF <b>1/5/61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grafton National</b>		23d. LOCATION (City, town, or county) (State) <b>Grafton, West Virginia</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14,</b>				25a. REC'D BY REGISTRAR <b>DATE JAN 9 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

CERTIFICATE OF DEATH

State of New York

County of New York

City of New York

Ward of New York

Block of New York

Lot of New York

Section of New York

Subsection of New York

Block of New York

Lot of New York

Section of New York

Subsection of New York

Block of New York

Lot of New York

Section of New York

Subsection of New York

Block of New York

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 716

## CERTIFICATE OF DEATH

00711

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>				c. LENGTH OF STAY IN 1b <b>32 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Schmidt</b>				4. DATE OF DEATH Month <b>Jan.</b> Day <b>20</b> Year <b>19 61</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 3, 1875</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Magnolia, Maryland.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.,</b>	
13. FATHER'S NAME <b>Charles Banglesdorf</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Guy L. Lackey Edgewood Md.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <b>arterial sclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 3</b> , 19 <b>59</b> , to <b>Jan 20</b> , 19 <b>61</b> , that I last saw the deceased alive on <b>Jan 20</b> , 19 <b>61</b> , and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Fred O. Hodous</b>		M.D.		ADDRESS (Street, city or town, state) <b>Edgewood Md</b>		DATE SIGNED <b>1-20-61</b>	
PHYSICIAN'S NAME (Type) <b>Fred O. Hodous</b>		<b>Edgewood Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 23, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Joppa, Harford, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. McCormick</b>		ADDRESS <b>Abingdon, Md.,</b>		24a. REC'D BY REGISTRAR <b>JAN 26 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2000

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 717 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00712

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>75X-3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willow Grove</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Doit Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>FRANKLIN</u> Middle <u>SIZER</u> Last <u>SIZER</u>		4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 6, 1921</u>
9. AGE (In years last birthday) <u>39</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Beer Distributor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beer Industry</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter Sizer</u>		14. MOTHER'S MAIDEN NAME <u>Estelle Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Audrey Sizer</u>		Address <u>138 E. Upshur St. Philadelphia, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractures mandible, R humerus, R tibia, R fibula</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>3</u> <u>1-1</u> <u>61</u> Hour <u>a.m.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NS Auto #1</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-1-61</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-7-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lawn Cemetery</u>		22d. LOCATION (City, town, or county) <u>Delaware County, Pa.</u> (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Bullock, Harre de Grace, Md.</u>		ADDRESS <u>556 Lewis St.</u>	
24b. REC'D BY REGISTRAR <u>JAN 4 '61</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10  
THE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1912

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, occupation, cause of death, and signature of the medical examiner.

NAME OF DECEASED: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ RACE: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

SIGNATURE OF MEDICAL EXAMINER: \_\_\_\_\_

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00713

718

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewood</b>		c. LENGTH OF STAY IN 1b <b>38 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Huston</b> Middle <b>L.</b> Last <b>Skelton</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>25</b> Year <b>1961</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June, 20, 1894</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>	
11. BIRTHPLACE (State or foreign country) <b>Hohenwald, Tenn.,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.,</b>	
13. FATHER'S NAME <b>Samuel M. Skelton</b>		14. MOTHER'S MAIDEN NAME <b>Martha Mathias</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Lucy E. Skelton</b>		Address <b>Edgewood Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>instant</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-5-61</b> to <b>1-25-61</b> that I last saw the deceased alive on <b>1-25-61</b> and that death occurred at <b>12 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>E. Louis Kahan</b> M.D.		<b>Box 966 Edgewood Md.</b>	
PHYSICIAN'S NAME (Type) <b>E. Louis Kahan</b>		<b>Edgewood Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 27, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Post Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Army Chemical Center, Md.,</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard M. Comas Jr</b> ADDRESS <b>Abingdon, Md.,</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 30 '61</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Hester, M. Elizabeth		July 1, 1954	
Age		38 years	
Sex		Female	
Race		White	
Marital Status		Married	
Cause of Death		Heart Disease	
Place of Death		Home	
Signature of Physician		J. Edgar Smith, M.D.	
Signature of Registrar		J. Edgar Smith, M.D.	
Date of Registration		July 1, 1954	
Place of Registration		Baltimore, Md.	

214701-10-10-54  
Approved  
J. Edgar Smith, M.D.  
Baltimore, Md.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
719  
CERTIFICATE OF DEATH

00714

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>		c. LENGTH OF STAY IN 1b <b>17 hrs 27 min</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>US Army Hospital Aberdeen Proving Ground, Md</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Infant Male</b> Middle <b>SPOONT</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>27</b> Year <b>19 61</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 27, 1961</b>
9. AGE (In years lost birthday) <b>17</b> yrs.		10. IF UNDER 1 YEAR Months <b>17</b> Days <b>27</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>M. Lawrence Spont</b>		14. MOTHER'S MAIDEN NAME <b>Lois Ann Liachowitz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>Father</b>		17. ADDRESS <b>717 Cambridge Avenue Aberdeen, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>776x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>17 hrs 27 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 27, 19 61</b> to <b>January 27, 19 61</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 27 19 61</b> , and that death occurred at <b>7:00 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Mark Eisenstein</b>		22b. DATE SIGNED <b>27 Jan 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARK EISENSTEIN Capt MC</b>		22d. ADDRESS <b>US Army Hospital Aberdeen Proving Ground, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-31-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Post Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Aber. Prov. Gd., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Tarring</b>		25a. REC'D BY REGISTRAR <b>FEB 2 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>		25c. ADDRESS <b>Tarring Funeral Home Aberdeen, Md.</b>	

2050272 xvo

CERTIFICATE OF DEATH

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

CHIEF OF BUREAU





CERTIFICATE OF DEATH

130

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS - BOSTON

Name of Deceased		Date of Birth		Sex	
Name of Father		Date of Birth		Sex	
Name of Mother		Date of Birth		Sex	
Place of Birth		Date of Death		Time of Death	
Cause of Death		Place of Death		Manner of Death	
Signature of Physician		Signature of Registrar		Signature of Coroner	
Date of Certificate		Date of Registration		Date of Filing	

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

721

## CERTIFICATE OF DEATH

Reg. Dist. No. 00716

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Louisa</u> Middle <u>Gustine</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>18,</u> Year <u>19 61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1865</u>
9. AGE (In years last birthday) <u>95</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Gilder Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Adams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Mildred Bailey</u>		Address <u>Forest Hill, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardio Vascular Disease.</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>57</u> , to <u>Jan.</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Jan.</u> , 19 <u>60</u> , and that death occurred at <u>11:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Md.</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson M.D.</u>		<u>Forest Hill, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-21-1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Highland cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Street Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 20 1961</u>	
ADDRESS <u>Delta, Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Charles B. ...</u>	

355

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 722 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00717

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Harford</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington Rural</u>			c. LENGTH OF STAY IN 1b <u>7 1/2</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Darlington Rural</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Hubert</u> First <u>Shepherd</u> Middle <u>Thompson</u> Last				<b>4. DATE OF DEATH</b> <u>January</u> Month <u>8</u> Day <u>19</u> Year <u>61</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 10, 1914</u>		9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Co.</u>				11. BIRTHPLACE (State or foreign country) <u>Penn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Elwood Thompson</u>						14. MOTHER'S MAIDEN NAME <u>Pearl Weil</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>218-09-3417</u>				17. INFORMANT <u>Mrs. Alice Thompson</u> Address <u>Darlington Md.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Gerald E Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>1-8-61</u>							
EXAMINER'S NAME (Type) <u>Gerald E Palmer MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bel Air, Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-11-61</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Southern Cem.</u>				22d. LOCATION (City, town, or county) (State) <u>Dublin Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James E. McMullen</u>						ADDRESS <u>Rising Sun Md</u>				24a. REC'D BY REGISTRAR <u>JAN 10 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thayer</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

72  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00718

1. PLACE OF DEATH a. COUNTY <b>Harford</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Aberdeen</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>R.D. #2 Agreement Laneway</b>				d. STREET ADDRESS <b>R.D. #2 Agreement Laneway</b>			
3. NAME OF DECEASED (Type or print) <b>JAMES EDWARD TIMMS</b>				4. DATE OF DEATH <b>January 16 19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 12, 1924</b>	
9. AGE (in years last birthday) <b>36</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mason Contractor</b>		11. BIRTHPLACE (State or foreign country) <b>Tennessee</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Kyle Timms</b>				14. MOTHER'S MAIDEN NAME <b>Emily Ward</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>414-42-8891</b>			
17. INFORMANT <b>George W. Timms, R.D. Aberdeen, Md.</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Stab Wound of Chest.</b> 982X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stabbed during altercation.</b>			
20c. TIME OF INJURY Hour <b>10:00</b> p.m. Month, Day, Year <b>1/16 19 61</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Aberdeen</b> (County) <b>Harford</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> <b>Homicide</b> <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Petty</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles S. Petty, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/21/61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grove Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Aberdeen, Maryland</b>	
23. FUNERAL DIRECTOR <b>John G. Tarring</b> <b>Tarring Funeral Home</b> <b>Aberdeen, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 25 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

100-100000

Agreement January 12, 1951  
Aberdeen  
Maryland

White  
January 12, 1951

Kyle Times  
Tennessee  
U.S.A.

George W. Times, P.D. Aberdeen, Md.  
Step Ward of Guest.

1:00  
Aberdeen  
Maryland

\_\_\_\_\_

Charles E. Perry, M.D.  
Aberdeen, Maryland

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

### 724 CERTIFICATE OF DEATH

00719

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford Grace</u>			c. LENGTH OF STAY IN 1b <u>49 Days</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>Toney</u> Last <u>Toney</u>			4. DATE OF DEATH Month <u>1</u> Day <u>28</u> Year <u>1961</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7/27</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bel Air MD</u>		11. BIRTHPLACE (State or foreign country) <u>US</u>	
13. FATHER'S NAME <u>Enos Rice Peaker</u>			14. MOTHER'S MAIDEN NAME <u>Alice Rice Chauncey</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or withdrawn) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Clarence Peaker</u> Address <u>230 N Bond St Bel Air MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Chz Cardiovascular disease with hypertension</u> DUE TO <u>cerebral hemorrhage with atelectasis</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>28 hrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u> Hour a. m. <u>  </u> p. m. <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1924</u> to <u>Jan 28, 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan 27, 1961</u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Willard P. Hudson</u>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS <u>Forest Hill, MD</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan 31/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Hudson Hill</u>	23d. LOCATION (City, town, or county) (State) <u>Bel Air Hartford Co MD</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hester Fur Home, Bel Air, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>JAN 31 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

CERTIFICATE OF DEATH

124

1001

I, the undersigned, being a duly qualified Medical Officer of Health for the City and County of Baltimore, do hereby certify that  
 the within and foregoing is a true and correct copy of the original record of the death of  
 [Name of Deceased] [Age] [Sex] [Color] [Race] [Religion] [Marital Status] [Occupation] [Residence] [Date of Birth] [Date of Death] [Place of Death] [Cause of Death] [Manner of Death] [Time of Death] [Signature of Medical Officer] [Date of Certificate]



CERTIFICATE OF DEATH

1234

George H. men  
Formerly of the  
United States Army  
Died April 20, 1900  
at the residence of  
his wife, Mrs. George H. men  
in the city of New York  
State, U.S.A.  
Cause of death  
Diphtheria

John C. Buchanan, M.D., of the County of Union, State of New York, hereby certifies that the foregoing is a true and correct copy of the original certificate of death filed in the office of the Registrar of the County of Union, New York, on the 21st day of April, 1900.



726

CERTIFICATE OF DEATH

Reg. Dist. No. 00721

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Edgewood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood R.D.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Van Bibber</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Stanton Samuel Tyson</u>		4. DATE OF DEATH <u>Jan. 1 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 13 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Tyson</u>		14. MOTHER'S MAIDEN NAME <u>Jane Tanny</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wife Ethel R. Tyson</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastro-intestinal Hemorrhage</u> DUE TO <u>Cancer of Stomach</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>26 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>Jan. 1</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec. 31</u> , 19 <u>60</u> , and that death occurred at <u>10:15</u> A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William A. Tyson</u> M.D.		ADDRESS (Street, city or town, state) <u>Kingsville, Md.</u> DATE SIGNED <u>1-1-61</u>	
PHYSICIAN'S NAME (Type) <u>William A. Tyson</u>		<u>Kingsville Maryland.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 4, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>West Nottingham</u>	22d. LOCATION (City, town, or county) (State) <u>Colora, Cecil, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. McKinnis Jr.</u>		ADDRESS <u>Abingdon, Maryland.</u>	
24a. REC'D BY REGISTRAR <u>AN 5 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

• KIN-VA-VA •

• *Environ. Sci. Technol.* 1991, 25, 1031-1036

727

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>HARFORD</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HARFORD</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural BEL AIR</b>		c. LENGTH OF STAY IN 1b <b>6 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural BEL AIR</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1 SCHUCKS ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM ROBBINS WARD</b>				4. DATE OF DEATH Month Day Year <b>JAN 9 1961</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 16 1879</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARM OWNER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GEN. FARM</b>		11. BIRTHPLACE (State or foreign country) <b>ASH CO. N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>WILLIAM WARD</b>				14. MOTHER'S MAIDEN NAME <b>MARY C. FOSTER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-12-6498</b>		INFORMANT <b>JACK B. WARD</b>		Address <b>Toppa MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA</b> <b>434.1</b> DUE TO <b>CONGESTIVE HEART FAILURE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>OLD AGE</b>							INTERVAL BETWEEN ONSET AND DEATH <b>60 MIN</b> <b>5 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB</b> 19 <b>58</b> , to <b>JAN</b> 19 <b>61</b> , that I last saw the deceased alive on <b>JAN 7</b> 19 <b>61</b> , and that death occurred at <b>10:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip W. Heuman</b>				ADDRESS (Street, city or town, state) <b>307 HICKORY, BEL AIR, Md</b>		DATE SIGNED <b>JAN 9 1961</b>	
PHYSICIAN'S NAME (Type) <b>PHILIP W. HEUMAN</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-12-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>EBENEZER</b>		22d. LOCATION (City, town, or county) (State) <b>FALLSTON MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Hurt</b>				ADDRESS <b>Jarrettsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 12 '61</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1937

(M)

(F)

1937

*[Faint, mostly illegible text on the certificate form, likely containing fields for name, date, cause of death, and registrar information.]*

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00723

728

See Birth Cert. et

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>07 X 1</u>	
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Girl</u> Middle <u>WEAVER</u> Last		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>8</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 8-1961</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>1</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u>1</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Curtis Morse Weaver</u>		14. MOTHER'S MAIDEN NAME <u>Joyce Elaine Taylor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>753.1</u> DUE TO <u>Pulmonary Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Multipl. Congen. f. l. defects</u> DUE TO (c) <u>Retention, Ears, Absence of lower jaw</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr 22 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-8</u> 19 <u>61</u> to <u>1-8</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>1-8</u> 19 <u>61</u> , and that death occurred at <u>10:52</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. DATE SIGNED <u>1/8/61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>1-8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>	23d. LOCATION (City, town, or county) (State) <u>Harre de Grace, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R. Tully Administrator</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 11 '61</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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For the purpose of maintaining the  
highway in good condition, the  
following items are required:  
1. Labor  
2. Materials  
3. Equipment  
4. Fuel  
5. Other

The following items are required for the  
purpose of maintaining the highway in  
good condition:  
1. Labor  
2. Materials  
3. Equipment  
4. Fuel  
5. Other



729

CERTIFICATE OF DEATH

Reg. Dist. No. 00724

1. PLACE OF DEATH a. COUNTY <b>Harford</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Bel Air</b>		c. LENGTH OF STAY IN 1b <b>2yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Bynam Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLOTTE A.</b> Middle <b>WHEELER</b> Last		4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 7, 1873</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William A. Hope</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Moore</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>John A. Webster, Jr., Pylesville, RD, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>420.1</b> (b) <b>Chr. Cardio-vascular disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>30 hrs.</b> <b>// ??</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 1958</b> to <b>Jan. 15, 1961</b> , that I last saw the deceased alive on <b>Jan. 15, 1961</b> , and that death occurred at <b>2:25 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Forest Hill, Md.</b> DATE SIGNED <b>1-15-61</b> ACTUAL SIGNATURE <b>Willard P. Hudson</b> PHYSICIAN'S NAME (Type) <b>Willard P. Hudson, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-18-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Catholic Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pylesville, Harford Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth W. Steuart</b> ADDRESS <b>Stewartstown, Penna.</b>		24a. REC'D BY REGISTRAR <b>JAN 18 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURC de GRACE</u>				c. LENGTH OF STAY IN 1b <u>19 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <u>Rt 1 Box 48</u>			
3. NAME OF DECEASED (Type or print) First <u>Wilmore</u> Middle <u>I.</u> Last <u>Sarah</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/1/1894</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Private Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>George Wilmore</u>				14. MOTHER'S MAIDEN NAME <u>Annie Williams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>				16. SOCIAL SECURITY NO. <u>191-16-2279</u>			
17. INFORMANT <u>Mr Eugene McCreary</u>				Address <u>Rt 1 Box 48 Haurc de Grace, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia with Cardiac Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aortic Aneurysm</u> DUE TO (c) <u>Hypertensive - Arteriosclerotic Heart disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> 19 <u>60</u> to <u>1/30</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>JAN 30</u> 19 <u>61</u> , and that death occurred at <u>9</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>George J. Stansbury</u>				22b. DATE SIGNED <u>1/31/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				22d. ADDRESS <u>569 Revolution Street Haurc de Grace, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/2/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Union Methodist Cemetery</u>				23d. LOCATION (City, town, or county) (State) <u>Chesapeake, Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer E. Sidork</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Kross</u>			
ADDRESS <u>Haurc de Grace, Md</u>				DATE <u>FEB 2 '61</u>			

CERTIFICATE OF DEATH

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CHIEF OF BUREAU

STATE OF NEW YORK

DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

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